28. School Based Services

Reimbursement will be statewide contract rates using uniform fees for each type of service such as, but not limited to: occupational therapy, speech therapy or nursing services. This contract rate will account for the resources necessary to deliver services including overhead costs. Consistent use of the statewide expenditure data will avoid duplication of direct and indirect cost categorization.

The statewide contract rates will be based on:

- Cost and utilization data provided by all state school districts to the Department of Public Instruction;
- Surveys of a cross section of school districts to establish the number of service units and the time necessary to provide them, some cost and related information; and
- Information on private sector providers of the same types of service.

Contract rates will be based on statewide cost and utilization data provided by the Department of Public Instruction. Additional data from other sources will be used as necessary.

This methodology is within the upper limits of payment set in 42 CFR 447.321 and 447.325 for outpatient hospital services and clinic services, and other inpatient and outpatient facilities.

The cost per unit (CU) for each covered service is calculated using the formula:

$$CU = \frac{DC + IC}{UC}$$

DC = The direct costs of health resources including staff and supplies.

IC = The indirect costs including administrative.

UC = The units of care related to direct and indirect costs.

Reimbursement of medical equipment for certified school based service providers will be on the same basis as referenced in the state plan amendment for medical equipment (see Attachment 4.19B, Page 6), and will be excluded from the above statewide contract rate for all other services.

Effective 4-1-99

29. Reimbursement for Unusual High Cost Home Care Cases

The Department, in its sole discretion, may establish an alternative payment for home health, personal care, private duty nursing and respiratory care services provided to a recipient if all the following requirements are met:

a. Medically necessary community based services, such as home health, personal care, respiratory care and private duty nursing services, are appropriate;

b. All applicable prior authorization requirements are met; and

c. The Department, in its sole discretion, determines, on an individual basis, that the recipient meets all the following criteria:

i. Annual cost of home care services is greater than $100,000;
ii. Institutional services are inappropriate; and
iii. Medical condition is not expected to improve; as a result, the need for services is not expected to change.

The home care services that may be considered for alternative payment include home health, personal care, private duty nursing and respiratory care services using the definitions and limitations described in the state plan. Services selected for an alternative payment will be those that are provided to the individual recipient consistently with little day-to-day variation and in relatively large quantities. Development of the per diem amount will include a determination of what proportion of the per diem is for which category of service. Claims for FFP for the per diem amounts will be separated into claims for each category of services based on the proportions.

The per diem amounts, which are interim payments, will be adjusted to reflect changes in services provided and provider-incurred costs on an as-needed basis, but no less than annually. Providers will be required to submit to the Department on at least an annual basis documented, audited costs for provision of services to individuals who qualify for alternative payments. The Department will also review the recipient's care plan and the prior authorization request. The per diem amount will not exceed the prevailing charges in the locality for comparable services under comparable circumstances. Per diem amounts will be redetermined annually, or earlier if there are changes in circumstances, such as changes in the recipient's condition or need for services, or in the quantity, quality, or cost of services being provided.

Upon determining the amount of an alternate payment to a provider, the Department will sign an agreement with that provider requiring appropriate recordkeeping and documentation. The Department will conduct periodic audits to assure that the recipient is receiving the authorized services, that the circumstances continue unchanged, and that FFP is claimed in appropriate portions. The Department will reconcile provider billing with provider-incurred cost at some specified point in time at least annually, and make necessary adjustments to reflect any over or under payment.

Effective 10-1-95

Substitute page

30. Reimbursement for Mental Health Crisis Intervention (MHCI) Services

Reimbursement for MHCI services will be based on the provider's actual cost to provide MHCI services. Interim rates will be established and providers will be required to complete yearly cost reports which will be used to make settlements. Cost reporting will be based on the allowable cost and cost findings principles detailed in the Office of Management and Budget Circular A-87. Costs will be based on the hourly cost to provide allowable services and will be determined for various levels of professionals and paraprofessionals working in the program (e.g., psychiatrist, psychologist, registered nurse). All the requirements of 42 CFR 447.325 will be met.

Effective 10-1-96

Replacement page issued 4-31-97

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE WISCONSIN

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item_____. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part A Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Coinsurance	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	___	full amount	___	full amount	___	full amount

* For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) outpatient hospital.

** Legal authority to implement is pending in state legislature, to be effective 7/1/89.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

ACCESS TO OBSTETRIC AND PEDIATRIC SERVICES

EXECUTIVE SUMMARY

The Wisconsin Department of Health and Family Services assures that Medical Assistance (Wisconsin Medicaid) recipients' access to obstetric and pediatric services is equal to that of the general population of the state. We demonstrate this under Category A of draft State Medicaid Manual Section 6306.1, "Practitioner Participation." We show that:

- In each of twelve substate regions of Wisconsin (defined as twelve geographic regions centered around one or more regional medical centers), at least 50% of the primary care providers available to the general public offer pediatric and obstetric services to Wisconsin Medicaid Program recipients, as evidenced by FY 1996 Medicaid paid claims data.

  Because Wisconsin is predominantly rural with a large number of health personnel shortage areas, many members of the general population must travel out of their communities to receive primary care services. Medicaid recipients must travel to the same degree as the general public. In light of these travel patterns, utilization was analyzed regionally in each of twelve substate regions.

- In addition, "border status" providers in Illinois, Iowa, Michigan and Minnesota are available to provide obstetric and pediatric services to both the general population and Medicaid recipients. Historically more than 900 border status primary care providers have been available to serve Wisconsin residents.

- The 1995-97 Biennial Budget contained a number of provisions favorable to promoting access to pediatric and obstetric services. These included:

  - Expansion of managed care services statewide. Wisconsin has operated a managed care program for AFDC and Healthy Start recipients in Milwaukee, Dane, Eau Claire, Waukesha and Kenosha counties.

    Beginning July 1, 1996, Wisconsin began statewide expansion of managed care programs for the Medicaid population. Enrollment is being phased-in during fiscal year 1997. When expansion is completed in May 1997, Wisconsin Medicaid expects to enroll up to 230,000 recipients in 68 counties in managed care.

    The goal of managed care is to provide primary care and other medically necessary services to Wisconsin Medicaid recipients in a manner more cost-effective than fee-for-service. Our initial experience in Southeastern Wisconsin has demonstrated that Medicaid recipients in managed care have greater access to primary care, immunizations and preventive services than their counterparts in fee-for-service.

- Reimbursement for primary care has been set at a level sufficient to ensure access to primary care by Medicaid recipients. These fee-for-service rates are reflected in Medicaid HMO capitation rates and contract provisions.

- Reimbursement for physician assistants and nurse midwives continues at 90% of physician reimbursement. Physician assistants receive the same reimbursement as physicians for immunizations, injections, lab handling fees and HealthCheck screens. Nurse practitioners receive the same reimbursement as physicians for all services they perform. These rates have been sufficient to assure access to these primary care providers.

These assurances clearly demonstrate that Wisconsin meets the provisions of Section 1926 of Title XIX of the Social Security Act.

INTRODUCTION

General Access

1995 Wisconsin Act 27 (the 1995-97 Biennial Budget) included a number of provisions favorable to promoting access to primary health care in Wisconsin. Most of these focused on the continued statewide expansion of managed care for Wisconsin Medicaid.

The Health Personnel Shortage Area (HPSA) incentive program continued to provide incentive payments for primary care services across the state. In FY 1996, 59 areas of the state were designated as Health Personnel Shortage Areas. (See Appendix 1 for a map of HPSA-designated areas.)

Wisconsin is fortunate to have a comparatively high percentage of physicians statewide who provide services to Medicaid recipients. In 1996, Wisconsin's Office of Health Care Information (OHCI) re-surveyed all physicians licensed in Wisconsin. (The original survey conducted in 1993 was used in previous editions of this state plan amendment.) The surveys were done in cooperation with the Wisconsin Department of Regulation and Licensing, which licenses health care professionals. The data was used in conjunction with Medicaid provider certification data to determine access to Medicaid providers by recipients.

Wisconsin Geographic Regions

Wisconsin is predominantly rural with only 19 of its 72 counties having the designation of metropolitan by the federal Bureau of the Census. By definition, rural counties lack sufficient population density to sustain the variety of economic enterprises that characterize urban counties. As a consequence, residents of rural counties often must travel substantial distances out of their home county to obtain necessary business and professional services.

This holds especially true for health care delivery. Residents of rural counties tend to travel to regional health clinics and hospitals to receive even primary health care. Health care services are so dispersed in Wisconsin that the state contained 59 federally designated Health Personnel Shortage Areas (HPSAs) in FY 1996. (See Appendix 1 for a map of HPSA-designated areas.)

Many Wisconsin residents located on Wisconsin's borders seek their health care across the state borders in more urbanized centers in neighboring Iowa, Illinois, Michigan, and Minnesota. Historically, more than 900 pediatricians, obstetricians, family practice and general practice physicians have been certified by Wisconsin's Medicaid Programs as "border status" providers eligible to provide services to Medicaid recipients.

From these analyses, it is clear the county is too small a unit by which to measure health care access. Using counties assumes: 1) that health care access is bounded by one's home county; and 2) that physicians practice in only one county. Neither assumption is true for the general population nor the Medicaid population in a rural state like Wisconsin. For a more complete picture of access, data must be aggregated into regions, each of which approximates normal travel patterns of the general population.

Therefore, as in previous editions of this plan, Wisconsin has elected to present the FY 1996 physician, nurse practitioner, and nurse midwife Medicaid participation data aggregated in 12 geographic health care regions centered around one or more regional medical centers. (See Appendix 2 for a map of the 12 regions.)

6306.1 Assurance of Adequacy of Access - The Department of Health and Family Services assures that the Medical Assistance (Medicaid) Program is meeting the requirements set forth in the Omnibus Budget Reconciliation Act of 1989 in this, the 1997 State Plan Amendment.

I. Pediatric Standards

A. Provider Participation

1. Number Participating

For the purposes of the pediatric standards section of this submission, participation by a provider in the Wisconsin Medicaid Program is defined as (1) having been certified by the Medicaid program as a physician (MD or DO), nurse practitioner, or nurse midwife and (2) having filed one or more claims for evaluation and management visits (office, preventive medicine or emergency room procedures), EPSDT comprehensive screens, or immunizations provided to Medicaid recipients aged 18-years and under during the period from July 1, 1995 through June 30, 1996. Because providers can have more than one specialty (e.g., obstetrics and family practice), a few were counted more than once as available to serve either the general public and/or the Medicaid population.

The number of Wisconsin pediatricians, family practice, and general practice physicians available to the general public who participate in the Wisconsin Medicaid Program meets or exceeds 50% of the total number of pediatricians, family practice, and general practice physicians practicing in all twelve health care regions. (Appendix 3-PED)

Note: Appendix 3-PED includes only fee-for-service data. HMOs do not collect data in a manner that enables the data to be included in this table.

Substitute Page

Of the 2,247 estimated primary care providers practicing in Wisconsin who offer pediatric care services, 2,185 or 96% provided fee-for-service pediatric services to Medicaid recipients in FY 96. (Appendix 3-PED)

2. How Data was Compiled on Physicians Available to Provide Pediatric Care to Wisconsin Residents

To estimate the number of pediatricians, family practice, and general practice physicians available to provide pediatric services to Wisconsin residents, data from the Wisconsin Office of Health Care Information (OHCI) and from the Medicaid program were used. This resulted in the creation of two databases. Both databases were aggregated by county and region.

The first database was composed of data from a 1996 collaborative effort between OHCI and the Wisconsin Department of Regulation and Licensing. This effort surveyed physicians licensed and practicing in Wisconsin in order to identify actively practicing primary care providers.

From this database, OHCI identified each physician's county and region based on the primary practice location of physicians who identified themselves as having a specialty in pediatrics, family practice, general practice, or obstetrics. Some providers identified more than one specialty and were therefore assigned to more than one specialty.

The second database contained actual FY 1996 fee-for-service Medicaid claims data. In this database, practice location was identified based on the first claim identified for each Medicaid certified provider. Provider specialty was also based on the Medicaid reference file created from certification information.

Appendix 3-PED lists the total number of physicians, nurse practitioners and nurse midwives, by county, providing pediatric services to the general public and to non-HMO Medicaid recipients. The number of providers serving Medicaid recipients is derived from fee-for-service Medicaid claims data. The number of providers serving the general public comes from the OHCI database. These data sources were also used to identify the number of family practice and general practice physicians specifically offering pediatric services to Medicaid recipients.